STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011840	A. BUILDING: _____ B. WING _____	C 05/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT PLACE WEST	55 N MISSION DR INDIANAPOLIS, IN 46214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00141363. Complaint IN00141363- Unsubstantiated due to lack of evidence. Survey date: May 7, 2014 Facility number: 011840 Provider number: 011840 AIM number: N/A Survey team: Megan Burgess, RN-TC Lora Brettnacher, RN Kewanna Gordon, RN Census bed type: Residential: 55 Total: 55 Census by payor source: Other: 55 Total: 55 Sample: 9 Summit Place West was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey and the Investigation of Complaint IN00141363. Quality Review 05/08/14 by Lisa McColly	R 000		